AHPS OFFER PROMISE, FACE OPPOSITION 4 | DRUG DISCOUNT PLANS WILL HURT, NOT HELP 7 | COVERING THE UNINSURED 10-11

HEALTH CARE NEWS

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# Drug Benefit Bill Heads to Senate Floor

Reuters

President George W. Bush addressed members of the Illinois State Medical Society about health care legislation during a visit to Chicago on June 11. Bush was using the trip to push for swift passage of legislation providing prescription drug coverage to seniors, despite lingering differences with the Republican-led U.S. Senate over the details.

**Conrad F. Meier and Diane Carol Bast**

Senate Finance Committee Chair Charles Grassley (R-Iowa) and Senator Max Baucus (D-Montana), the committee's ranking Democrat, have reached agreement on a $400 billion, 10-year Medicare reform proposal. The Committee considered the bill in executive session on June 12, approving the bill late in the day by a 16-5 vote. The full Senate began debate on June 16.

The "Prescription Drug and Medicare Improvement Act of 2003" would give beneficiaries access to private health insurance plans but allow them to remain in government-run Medicare if they prefer. All Medicare beneficiaries would be offered an identical prescription drug benefit, regardless of which coverage they selected.

President George W. Bush emphasized the need for Medicare reform in his June 7 weekly radio address and during a June 11 trip to Chicago. "Time and time again," Bush told members of the Illinois State Medical Society, "Medicare's failure to pay for drugs

Rx BILL continued on page 14

## States Tackle Liability Reform

**Conrad F. Meier**

Legislative proposals offered recently in three states illustrate the types of solutions policymakers are reaching for in an effort to control runaway medical malpractice insurance premiums.

Like many other states with reform measures pending, Florida, New Jersey, and Texas have been unwilling to wait for action from Congress, where liability reform has stalled as federal policymakers focus on Medicare reform and prescription drug benefits. (See "Malpractice Reform Takes a Hit," *Health Care News*, May 2003.)

LIABILITY continued on page 5

## Consumer-Driven Plans Blooming

**Greg Scandlen**

Health insurance products designed to give consumers a bigger say in their coverage—and consequently become more discriminating consumers of health care services—are multiplying at a dizzying pace.

**HRAs and High Deductibles**

"Small business owners aren't quite nervy enough to impose a high-deductible insurance plan on their employees," reports Ann Meyer in the April 21 edition of the *Chicago Tribune*. So, she writes, employers are turning to creative thinking to soften the blow.

CONSUMER continued on page 8

## Maryland Launches New High-risk Pool

**Conrad F. Meier**

Beginning this month, Maryland will offer a new health insurance program to residents unable to obtain private insurance because of high risk and preexisting medical conditions.

The program, a form of high-risk insurance pool, will be named the Maryland Health Insurance Plan (MHIP).

Mary Spear, state affairs director for the Council for Affordable Health Insurance, praised the measure.

"The Maryland Insurance Plan is another example of how high-risk pools can serve

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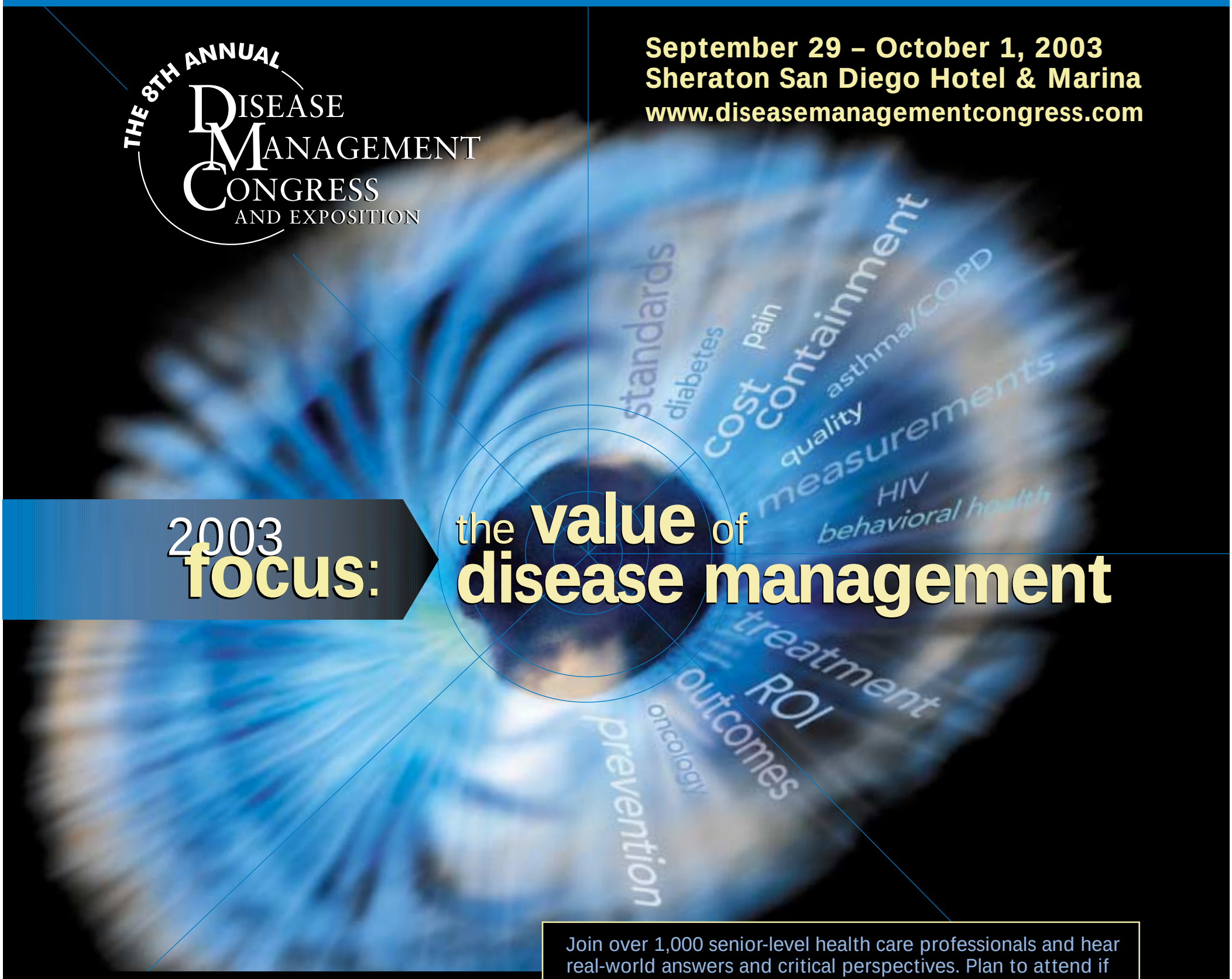


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# Moseley Braun, Edwards Join Health Plan Debate

**Conrad F. Meier**

**Moseley Braun: My Plan Is "Radical"**

Democratic Presidential hopeful and former Illinois Senator Carol Moseley Braun is in the early stages of developing a "radical" and "ambitious" health care plan designed to cover the uninsured and provide prescription drug coverage for seniors.

In an interview with *The Hill*, a congressional newspaper, Moseley Braun said she intends to "decouple" health insurance from employment because many people are unemployed, self-employed, or work for small businesses where they cannot obtain health insurance.

The former senator also said she would offer a universal, comprehensive health plan modeled after the Federal Employees Health Benefit Program. Moseley Braun asserted insurance companies should be payers only, and should not be in the health care policy-making business.

In an attempt to reduce the government's health care bureaucracy, Moseley Braun would, in her words, "add an ambitious" twist to her reform approach by combining different payment systems, including Medicare and Medicaid. She offered no details.

To pay for this new health care system, Moseley Braun said she would raise income taxes and eliminate "employment taxes" such as the Medicare payroll tax. "I haven't run the numbers yet," she acknowledged.

While admitting every U.S. resident "gets health care now," Moseley Braun said "the way we pay for it is out of whack." She intends to unveil her complete plan in early fall.

"While admitting every U.S. resident 'gets health care now,' Moseley Braun said 'the way we pay for it is out of whack.' She intends to unveil her complete plan in early fall."

*Zuma Press*

**Edwards: My Plan Is "Focused"**

Senator John Edwards (D-North Carolina), also stumping for the Democratic Party's Presidential nomination, is also now touting a health care plan. Edwards called prescription drugs "one of the largest factors driving up health costs" and has proposed ways to lower prices.

Seven of nine Democratic candidates have advanced plans for addressing the rising cost of health insurance premiums. Edwards' proposal is notable in its narrow focus on prescription drug costs.

Accusing pharmaceutical manufacturers of unfair dealings with consumers, Edwards said his plan would:

- Hold pharmaceutical drug advertising to higher standards of accuracy.
- Stop "backroom deals" between drug companies and the pharmacy benefits managers hired by health plans to negotiate for bulk prices, and mandate that any negotiated price breaks be passed on to consumers.
- Give government more latitude to negotiate lower bulk prices for the Medicare and Medicaid programs.
- Launch a comprehensive Justice Department investigation of drug costs paid by the government. Create fines and penalties for companies that overcharge.
- Close legal loopholes that allow drug companies to extend patents and keep cheaper generics off the market.
- Establish a commission to review patent laws and recommend changes.

Edwards is quoted in a June 6 Associated Press wire story saying the nation must decide "whether we put consumers or corporate interests first." He added, "We need the pharmaceutical industry. They develop therapies that save people's lives and medicines that improve our quality of life, and they deserve a good profit for that important work. But they don't deserve to inflate that profit by stifling competition, gouging consumers, and cutting secret deals—all at the expense of patients and taxpayers."

The *Los Angeles Times* reported Edwards wants the federal government to provide seniors with a prescription drug benefit administered by Medicare, rather than by private health plans. Edwards said he would "impose unilateral price reductions for Medicare purchases" of prescription drugs in the event Medicare cannot negotiate adequate discounts with pharmaceutical companies.

According to campaign aides, Edwards will introduce a much broader proposal to expand access to health insurance in July.

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# Association Health Plans Offer Promise, But Face Opposition

## *Experts say proposals would give millions access to insurance*

**Greg Scandlen and**
**Conrad F. Meier**

Allowing individuals and small businesses to purchase health insurance through associations, called Association Health Plans (AHPs), has the backing of civic and business groups representing millions of families nationwide. But opponents of AHPs are trying to block legislation that would make it easier for insurers to sell through associations.

**Federal Deregulation**

The "Small Business Health Fairness Act of 2003" is currently under consideration in the House Education and the Workforce Committee (HR 660IH) and Senate Committee on Health, Education, Labor, and Pensions (S 545).

The bills would authorize the formation and multi-state operation of federally certified AHPs, allowing small businesses to group together to purchase affordable insurance through their trade associations, giving them the economies of scale and administrative efficiencies currently enjoyed by large employers and unions. Several states already authorize AHPs; the two federal measures would regulate them for financial solvency and truthful representation under one federal law, instead of the diverse insurance laws of the several states.

**"AHP reform could encourage employers to extend insurance coverage to approximately 2.3 million workers and 2.2 million dependents."**

The House measure, sponsored by Ernie Fletcher (R-Kentucky), currently has 159 sponsors and cosponsors, while the Senate measure, introduced in March by Olympia Snowe (R-Maine), has seven cosponsors. The National Federation of Independent Business is among the many small business groups supporting the bills.

**Insuring the Uninsured**

Millions of Americans are currently not covered by health insurance. Many of them would have access to affordable coverage through AHPs.

- A Congressional Budget Office (CBO) analysis of legislation pending in Congress estimates small businesses would save between 9 percent and 25 percent of the cost of their health insurance premiums if AHP reforms were enacted.
- As a result, the CBO estimates at least 330,000—and as many as 2 million—of the currently uninsured would obtain health insurance.
- CONSAD Research Corporation estimates AHP reform could encourage employers to extend insurance coverage to approximately 2.3 million workers and 2.2 million dependents.

**Critics Question Benefits**

Reporter Joel Finkelstein noted in the May 19, 2003 edition of *AMNews*, "The American Academy of Actuaries (AAA) and 38 state attorneys general have joined the ranks of those opposing [AHP reform] bills in the House and Senate."

In a letter to Rep. John Boehner (R-Ohio), chairman of the House committee, the AAA says, "While the goals of the legislation are laudable, the bills do not address the core problem, which is the high cost of health care." One of the key factors driving insurance premium increases is over-regulation, and the AAA doubts whether the AHP measures address that problem.

Finkelstein cites other concerns expressed by opponents: that AHPs will "fragment" the insurance pool, "cherry-pick" healthy employees, and raise premiums for the majority of workers. Similar concerns, later disproven, were raised in the infancy of Medical Savings Accounts, defined contribution, and other reform approaches designed to return decision-making and purchasing power to consumers.

**Advocates Have Answers**

In an April 2003 report issued by the National Center for Policy Analysis, "Insuring the Uninsured through Association Health Plans," economist Donald Westerfield of Webster University explains how AHPs would address the problem of uninsurance.

"One of the unintended consequences of increasing government regulation was to increase the numbers of people without health insurance," he writes. "The high cost of complying with different state regulations has raised the cost of employer-sponsored health plans, leading many small businesses to drop coverage altogether."

Westerfield describes state-level regulations that serve as a barrier to affordable health insurance and explains how a lack of uniform regulation across all states negatively affects the insurance market.

"If small firms could buy AHP insurance," Westerfield writes, "with guaranteed uniform regulation, they could enjoy the same lower administrative costs now available to large company health plans that are federally regulated. AHPs would also be able to avoid mandated benefits and other complex, cost-increasing regulations that are imposed in different states.

"These are plans created for individuals and groups who belong to associations that are related to jobs, careers, or hobbies and interests," explains Westerfield. "The potential for growth of this type of insurance is quite large—given a favorable regulatory climate."

www.snowe.senate.gov

www.house.gov

The "Small Business Health Fairness Act of 2003" is being sponsored in the Senate by Olympia Snowe (above) and in the House by Ernie Fletcher (right).

**Millions Could Benefit**

According to a May 28 *Wall Street Journal* report, the National Federation of Independent Business—the largest backer of federal Association Health Plan (AHP) legislation—would gain more than $100 million in annual revenue if the bill exempting AHPs from state insurance regulations is passed.

"By uniting many small groups with similar interests across the country," Westerfield explains, "AHPs could take full advantage of economies of scale to lower health care costs for their memberships. There are about 15,000 associations throughout the country, and some six million Americans are insured through associations ... and the number is growing."

Among the groups that might benefit from AHP deregulation:

- AARP—the American Association of Retired People—which offers supplemental medical insurance to all of the Medicare enrollees among its 35 million dues-paying members.
- the National Association for the Self-Employed (NASE), which currently makes AHP insurance available to its members throughout the country.
- the National Restaurant Association and National Rifle Association, which could offer AHP insurance to employees or members in all 50 states.

**Business Community Is Divided**

AHPs have not, however, attracted across-the-board support from the business community.

In Washington State, notes Peter Neurath in the May 3 *Puget Sound Business Journal*, the Association of Washington Business and the Greater Seattle Chamber of Commerce wrote to state senators claiming AHPs would "destabilize the market and render small employers' health insurance reforms unworkable." The article identifies other AHP opponents, including the state hospital association, medical society, the local Blues plans, and the insurance commissioner.

By contrast, business groups in Ohio support a state-based AHP bill allowing associations to "pool their workers for health insurance rating purposes," according to Jeff Bell in the April 4 issue of *Business First of Columbus*. The measure is supported by the Ohio National Federation of Independent Business, Chamber of Commerce, Business Roundtable, Manufacturers Association, Retail Merchants Association, and Farm Bureau, known collectively as the "Big Six."

The Ohio bill will relax state regulations and strengthen anti-trust laws, according to Bell. Local attorney William Todd expects the bill to encourage the development of "more complex insurance programs that hold out hope for reasonable control of health care costs," including consumer-driven plans like Health Reimbursement Arrangements.

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**INTERNET INFO**

The House and Senate versions of the Small Business Health Fairness Act of 2003 are available through *PolicyBot*. Point your Web browser to **http://www.heartland.org**, click on the *PolicyBot* icon, and search for documents **#12359** (S. 545, 70pp.) and **#12360** (H.R. 660, 72pp.).

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# Maryland

Continued from page 1

as a safety net for uninsurable individuals," she said. "CAHI commends Maryland for its commitment and dedication to serving the unique needs of its uninsurable citizens."

Lee Tooman, vice president of government relations for Golden Rule Insurance Company, agreed. "Golden Rule is very pleased Maryland has joined the majority of states in enacting a comprehensive health insurance plan for uninsurable persons and persons eligible through HIPAA," said Tooman.

"MHIP is the ideal vehicle to provide the coverage. It can promote itself and reach out to eligible persons so they don't slip through any cracks. It subsidizes their premiums so they can afford the coverage."

MHIP will be funded by assessments on Maryland hospitals, a mechanism Tooman approved. "Maryland established a very broadly based mechanism for the subsidy so everyone in Maryland will help with the subsidy, not just the relatively few people with fully insured health insurance plans.

"The hospitals themselves supported this method of subsidy," said Tooman, "because they felt a lot of uncompensated care would be eliminated. We agree"

**SAAC Replacement**

MHIP replaces an existing program, Substantial, Available and Affordable Coverage (SAAC), established in 1970. Under the SAAC plan, insurers and HMOs were given discounts on hospital rates in exchange for accepting all applicants during two open enrollment periods per year.

SAAC provides coverage to roughly 7,500 residents through three participating health plans, including CareFirst BlueCross BlueShield. All three insurers had threatened to abandon the program.

Critics of SAAC said the insurers received millions of dollars in hospital discounts to provide coverage to participants, but the program's premiums were so high it discouraged participation, leaving too many people without access to coverage.

**Capped Premiums**

Richard Popper, who has been named executive director of MHIP, said benefits under the new program would be similar to those offered by SAAC. He expects that after one year in operation, enrollment in the new plan will be twice the enrollment achieved by SAAC—at least in part because eligibility for MHIP has been extended to Bethlehem Steel retirees who lost their company-sponsored health benefits, and to workers at a Black & Decker plant that is closing.

Providers offering coverage under the new MHIP may not charge premiums less than 110 percent or more than 200 percent of the standard risk-calculated rate. Premiums will decrease for about 66 percent of current SAAC participants. For participants in the SAAC's HMO plan, premiums will increase by between $42 and $120, because those premiums have been so low as to be unsustainable.

**"Richard Popper, who has been named executive director of MHIP, ... expects that after one year in operation, enrollment in the new plan will be twice the enrollment achieved by SAAC ..."**

MHIP participants will be able to enroll year-round, rather than only during the SAAC open enrollment periods. Participants will be able to switch health plans once a year.

Participants will be permitted to see their current doctors for the first 90 days of the new program, after which time they must use a doctor participating in MHIP. According to Popper, about 300 of the 3,500 doctors and medical groups that served SAAC have joined the new program.

MHIP participants will be able to enroll in a preferred provider organization, under which they will pay a deductible, or apply to an exclusive provider organization, which does not have deductibles but charges higher premiums.

"High risk pools are a proven means of addressing the uninsurable problem in the states," CAHI's Spear noted. "Congress has demonstrated its confidence in the success of high-risk pools by committing $40 million to states which meet federal guidelines for establishing and managing high risk pools.

"Maryland is a leader in (1) meeting those federal guidelines and (2) recognizing the gravity of the uninsurable problem and implementing a responsible plan to address the issue," she said.

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# Liability Reform from Florida to Texas

Continued from page 1

**Florida: Bush Unveils Reform**

Governor Jeb Bush (R) called on state lawmakers to return to the legislature on June 16 for a four-day special session to address the increased cost of malpractice insurance in the state. He promised to "call them back, again and again" until they resolve the issue.

Bush also unveiled a 52-page liability reform bill, which includes a $250,000 cap on non-economic damages in malpractice lawsuits and would require malpractice insurers to reduce premiums by 20 percent by October.

The Bush proposal is similar to legislation approved by the state house but defeated by the state senate last month. Opponents maintain the measure has loopholes and might not lead to reduced malpractice insurance premium rates.

**Rate Cuts Required**

The bill would require malpractice insurers operating in the state to reduce premium rates by 20 percent on average—by more for physicians in low-risk specialties, with smaller rate reductions for those in high-risk specialties.

The loophole pointed to by critics is a provision that would allow insurers to bypass the rate reductions requirement in cases where it would "prevent them from making a profit."

The bill also requires hospitals and physicians to inform patients about medical errors; orders state regulators to determine what information consumers should have to help them select physicians and hospitals; and increases the authority of the Florida Board of Medicine to discipline physicians. Opponents say the provisions are "vague and virtually unenforceable."

**Attorney Fee Caps Proposed**

State Representative Connie Mack (R) has proposed a ballot measure that would amend the state constitution to cap the fees plaintiffs' attorneys could receive in malpractice lawsuits.

The measure would allow attorneys to receive up to 30 percent of the first $250,000 a plaintiff receives in a malpractice lawsuit. The remainder of the first $250,000 would go to the plaintiff—as would 100 percent of any awards more than $250,000. Mack has formed the Victim's Compensation Coalition, a group that hopes to place the measure on the ballot in November 2004.

**New Jersey: McGreevey Proposes Dr. Subsidies**

Governor Jim McGreevey (D) rejected legislation approved by the state senate in March that would cap non-economic damages in malpractice lawsuits, proposing instead the state establish a direct cash subsidy for physicians "hit hardest by insurance increases."

His proposal is similar to a bill introduced in the state assembly by Majority Leader Joseph Roberts (D). It would establish a state fund of $150 million over the next five years that could cover as much as half of malpractice insurance premium increases for physicians in high-risk specialties.

State Senate Co-President John Bennett (R) said the body would not approve McGreevey's proposal. The senate had voted 32-5 to cap at $300,000 non-economic damage awards in malpractice lawsuits and to allow plaintiffs to collect as much as $700,000 more from a state fund.

*www.state.nj.us*

New Jersey Governor Jim McGreevey (D) rejected legislation approved by the state senate in March that would cap non-economic damages in malpractice lawsuits.

**More Data Sought**

The senate also voted, unanimously, to approve revisions recommended by McGreevey to a bill giving the state Division of Consumer Affairs more authority over an online directory of physicians. The directory will include information on the medical schools physicians attended, the number of years they have practiced, and disciplinary actions or malpractice verdicts against them in the past five years.

The state assembly's health and insurance committees announced they will seek subpoenas to force insurers in the state to submit data related to increased malpractice insurance premiums.

**Texas: Model Reform Package**

Policymakers in the Lone Star State have passed a package of legal liability measures that includes significant medical malpractice reform, offering hope that a working model for other states and Congress could soon be in place.

House Bill 4 caps at $250,000 non-economic damage awards against individual providers; $250,000 on damage awards against individual hospitals; and $500,000 on damage awards against two or more hospitals. Governor Rick Perry (R) has indicated he will sign the bill.

An editorial in the *Wall Street Journal* reported "frivolous lawsuits" are taking a "heavy toll" on Texas, noting the state can "thank the trial lawyers" for the fact there are 300 lawsuits for every 100 doctors in some parts of the state. More than 150 of the state's 254 counties have no obstetrician.

"Republicans in Washington and especially in the filibustering Senate, need to display the same will as Texas," the editorial advised, adding "President Bush says he's serious about federal tort reform. His party could help by giving him some bills to sign."

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# Governor Abandons Maine Rx Plan

**Conrad F. Meier**

Democratic Governor John Baldacci on May 30 formally abandoned plans for Maine Rx, submitting a proposal to the legislature for an alternative discount prescription drug plan called Maine Rx Plus. The plan is one element of the sweeping Dirigo Health strategy set forth by the governor in early May.

"Dirigo," the state's motto, means "I lead."

The revamped prescription program, which if approved by the state legislature would go into effect by January 1, 2004, would provide discounts to fewer people and would be less expensive than the original.

Baldacci's decision followed the U.S. Supreme Court's May 19 ruling to lift an injunction on Maine Rx. Under that program, enacted in 2000, the state would have pressured pharmaceutical companies for additional rebates and discounts on prescription drugs equal to or larger than those set by federal law for the Medicaid program.

"Maine is moving very fast toward government-run single-payer health insurance," warns Scott K. Fish, director of special projects for the Maine Public Policy Institute. "The revised Maine Rx program is part of that movement. Maine's new Dirigo Health Plan is another part."

The legislature approved Dirigo Health on June 13.

**Original Maine Rx**

The original Maine Rx Program authorized the state to act as benefits-manager on behalf of residents without prescription drug benefits. In that role, the state would seek to extract rebates and discounts from drug manufacturers in order to lower the price of prescription drugs.

The Pharmaceutical Research and Manufacturers of America (PhRMA) challenged the program in court, contending it violated the U.S. Constitution's Commerce Clause and was preempted by the federal government's Medicaid Act. A District Court agreed, enjoining the state from implementing the program, but the First Circuit Court of Appeals reversed that decision.

**"Maine Rx Plus is expected to cost the state about $800,000 in the next fiscal year and $2 million the following year."**

The U.S. Supreme Court's ruling affirmed the appeals court's decision and would have allowed Maine Rx to go into effect even while the case proceeded on its merits through the courts. But Baldacci opted instead to jettison Maine Rx in favor of the new proposal.

**New Maine Rx Plus**

When the PhRMA suit was argued before the Supreme Court in January, several Justices raised concerns about certain program components, leading Maine officials to scrap the original program in favor of Maine Rx Plus.

Maine Rx Plus is expected to cost the state about $800,000 in the next fiscal year and $2 million the following year—considerably less than Maine Rx's projected annual cost of $4.5 million. An estimated 275,000 people would be eligible for the Maine Rx Plus drug discounts, fewer than the 325,000 eligible under the original program.

The Supreme Court had challenged the original program for lack of income caps on eligibility. Maine Rx Plus corrects that flaw, limiting eligibility to persons earning up to 350 percent of the federal poverty level—$31,430 for an individual, or $42,420 for a couple.

In addition, Maine Rx Plus offers significantly larger discounts on prescription drugs included in the state formulary than those planned under Maine Rx, according to Jude Walsh of the state's Department of Human Services. The new discounts, which supporters of the plan say would range from 15 to 60 percent, would be funded by the state in full until Maine is able to negotiate rebates with drug makers.

"The perception of the average Mainer," says MPPI's Fish, "is that Maine Rx Plus will offer free drugs. It will not. It offers discounts only on certain drugs government bureaucrats add to the formulary because they decree them to be medically effective and reasonably priced."

**Formulary Issues**

A formulary is a list of prescription drugs covered by a government program (or occasionally, a private insurer) under terms more favorable than other drugs. Drugs on a state government's Medicaid formulary, for example, generally do not require a doctor to get prior authorization from state health care bureaucrats before prescribing them.

According to David Chess MD, founder, chairman, and president of Project Patient Care (**www.projectpatient care.org**), a nonprofit organization committed to improving patient care, "Prescribing medicines based on drug formulary restrictions has become an accepted health care practice. Medications prescribed using these restrictive formularies, however, may not always be medically appropriate or even safe for some patients."

A Harris Interactive poll commissioned by Project Patient Care found formulary restrictions can lead physicians to prescribe a drug that's on the formulary simply because it's more convenient or less expensive to do so, even if the physician's preferred drug would work better for the patient. Such medicine-switching can pose a threat to patient health, especially for older Americans, who tend to be more reliant on drugs than younger patients.

According to the *Portland Press Herald*, Democratic lawmakers have embraced the new Maine Rx Plus plan. House Republican Leader Joe Bruno said there was no opposition to the plan from his side of the aisle.

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**INTERNET INFO**

The Harris Interactive survey, "Are Pharmaceutical Formularies Medically Safe?" is available on the Internet at **http://www.pfizerforum.com/english/chess.shtml**.

The full text of the U.S. Supreme Court's decision on Maine Rx is available through *PolicyBot*. Point your Web browser to **http://www.heartland.org**, click on the *PolicyBot* icon, and search for these documents: **#12361** Syllabus (5pp.); #**12362** Opinion of the Court (24pp.); **#12363** Concurring Opinions of Breyer, Scalia, and Thomas (17pp.); **#12365** Opinion of O'Connor (7pp.)

# Judge Overturns Mass. Tax on Rx

**Conrad F. Meier**

Superior Court Judge Allan van Gestel has overturned a state prescription drug tax and said government officials must return to pharmacies statewide $18 million in revenue collected from the tax, which took effect January 1.

Through the end of the fiscal year, June 30, the tax was set at $1.30 per prescription. The tax would have fallen to 65 cents per prescription on July 1. Expected to raise $36 million a year, the tax affected an estimated 55 million prescriptions. Prescriptions for Medicaid and Medicare beneficiaries were exempt.

Van Gestel ruled the state had improperly implemented the tax and rejected the state's claim it had obtained federal approval. CVS, Brooks Pharmacy, and dozens of other pharmacy chains filed suit against the state in April to block the tax.

Attorneys for the state said the Division of Medicaid Assistance received a letter approving the tax on December 23 from the federal Centers for Medicare and Medicaid Services (CMS). But van Gestel ruled the letter was "too vague to constitute approval. What the correspondence shows, in plain language, was not federal approval of anything," he told the *Boston Globe*.

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# State Drug Discount Plans Likely to Hurt More than They Help

**Nina Owcharenko**

On May 19, a 6-3 ruling of the U.S. Supreme Court gave a green light to Maine Rx, the State of Maine's plan to extract prescription drug discounts, or rebates, from pharmaceutical manufacturers for drugs sold to consumers without prescription drug coverage.

Maine Rx has been tied up in court since it was approved by the legislature in 2000.

The Court's decision was not an endorsement of prescription drug rebates. As is its job, the Court ruled on matters of law only.

Policymakers now should do *their* jobs by re-evaluating the effects such a government pricing proposal would have on the delivery of health care.

**Unintended Consequences**

Under Maine Rx, the state would lower the price of prescription drugs for residents without prescription drug coverage by requiring pharmaceutical manufacturers to pay a rebate similar to that offered under Medicaid.

The sponsors of Maine Rx offered it with the best of intentions. But their program is based on fundamentally erroneous assumptions and, as a result, its effects will be the very opposite of what they intended.

Federal law already requires pharmaceutical manufacturers to provide rebates, averaging about 20 percent off the retail price, to states for drugs that are supplied through the Medicaid program. Under Maine Rx, the state would require a similar discount for drugs prescribed to the expanded population served by the new program.

The state would impose a prior authorization requirement on the drugs of any manufacturer who opted not to discount its drugs for the Maine Rx population. This would make it more difficult for doctors to prescribe those drugs, ultimately restricting patient access to life-saving and life-improving medicines.

If Maine were successful in getting drug manufacturers to offer further discounts, other states would follow. Widespread demand for discounts could lead some pharmaceutical manufacturers simply to raise the base price of their drugs in order to recoup the discounts—essentially government-caused prescription drug price inflation.

Alternatively, drug manufacturers might cut expenses (to reflect the lower revenues they receive) by reducing their investment in research and development. Pharmaceutical firms invest billions of dollars every year in the research that is necessary to develop breakthrough treatments and cures. If those firms are making less money on the drugs they sell, they will have less money to invest in new drugs.

**Mandates Are Not Negotiations**

The advocates of Maine Rx say they are hoping to mimic the purchasing power of large private-sector entities by acting as pharmacy benefits manager for the state's uninsured population. But in the private sector, discounts are *negotiated*, not mandated or secured by threat.

Some public-sector programs successfully mirror the private sector's process of negotiation. Individuals covered by the Federal Employees Health Benefits Program (FEHBP), for example, are able to choose from competing plans that offer a variety of coverage options, including coverage for prescription drugs. A less-costly plan offers a restricted prescription drug benefit, while another plan is more costly but offers a broader drug benefit. The individual chooses the plan that best suits his or her needs.

**Making Matters Worse**

Maine Rx would weaken an already-suffering patient-doctor relationship. The prior authorization requirement is a burden on physicians and restricts their ability to treat patients as they see fit. State governments have already interfered in this relationship, most recently with cost-cutting efforts that limit the supply of prescription drugs available to Medicaid beneficiaries. Access to health care is not improved when a physician's treatment decisions increasingly require the approval of government bureaucrats.

Maine Rx would also jeopardize existing private insurance coverage. When government-run health care programs are expanded, private programs are invariably contracted. Maine Rx targets individuals without prescription drug coverage. Individuals who are self-insured and employers—especially small businesses for whom employee insurance coverage is a costly benefit—might very well drop prescription drug coverage from their plans, knowing Maine Rx will be there to pick up the pieces. This is not a consequence to be encouraged.

**Need for Congressional Action**

The majority of Americans without prescription drug coverage are either elderly on Medicare with no supplemental prescription drug coverage or uninsured. Two key changes in federal policy would significantly improve their situations.

- *Comprehensive Medicare reform*. By integrating prescription drug coverage into a full package of health insurance, based on the FEHBP model, senior citizens without prescription drug coverage would have access to a variety of coverage options.
- *Expanding coverage for the uninsured*. Providing uninsured individuals with refundable health care tax credits would enable individuals to obtain the insurance coverage that best suits their needs, including access to the prescription drugs of their choice.

**Alternatives for the States**

While federal policymakers continue to work toward reform, states can and should adopt innovative approaches based on consumer-directed principles that improve the overall financing and delivery of medical care.

For example, state officials could encourage enrollment in existing private discount drug programs and provide financial assistance to individuals who need help covering co-pays or annual enrollment fees. (See "Stop Demonizing the Good Guys," *Health Care News*, November 2001.)

Such an approach has been proposed at the federal level by health policy analysts at the American Enterprise Institute (AEI) and Galen Institute to address the need to secure prescription drug coverage for the minority of Medicare patients who do not have it. This approach could easily be replicated by the states.

Also, adapting consumer-directed approaches within Medicaid, such as the highly successful "cash-and-counseling" programs tested in Arkansas, Florida, and New Jersey, would allow individuals to determine which drugs and treatments they want to purchase.

**Limiting Government's Role**

Maine Rx's goal—to provide affordable prescription drugs—is a good one, but the program's method is based on the flawed assumption that government bureaucrats are best equipped to make key health care decisions on behalf of patients.

On the contrary, the best way to ensure individuals have access to the prescription drugs and treatments they need and want is to allow them to make those decisions on their own, limiting the government's role to financially assisting low-income persons who need it.

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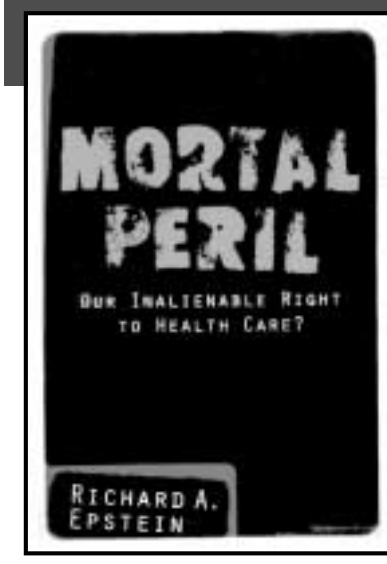


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# Consumer Plans

**Continued from page 1**

A June 2002 Internal Revenue Service ruling, for example, has sparked interest among employers in Health Reimbursement Arrangement (HRAs). "The reaction to this has been overwhelming," says John DiVito of Flexible Benefit Service Corp., who is quoted in Meyer's report. HRAs complement any type of insurance plan, Meyer notes, and the employer need not pre-fund the account.

A banking trade group in Chicago paired a Blue Cross/Blue Shield plan with an HRA. Meyer explains how the group increased its BC/BS hospitalization deductible to $1,000 (from no deductible) and is using the HRA to help pay $750 of the deductible. The HRA does not roll over from one year to the next, but employees get the advantage of a reduced premium.

Meyer also talks with Patrick Moore of Diversified Insurance Services, who warns employers against managing their own HRA funds. "You don't want to be handling explanation of benefits for people," Moore says, "because you would be getting information you shouldn't have." To avoid having to traverse complex privacy rules, Moore recommends employers use a qualified third-party administrator to handle HRA funds.

**HRAs and PPOs**

In an interesting observation on the development of the consumer-driven marketplace, Meyer writes "HRAs with standard PPOs ... are generally less expensive than their sister products: the consumer-driven health plans offered by insurance companies." The latter are more expensive, Meyer says, because they offer intensive consumer education and support.

While Meyer's assessment might well hold true in the first year or two of coverage, it raises a question about longer-term effects. Will consumers become better shoppers armed only with the financial incentives to do so, or must they have the education and support offered by insurance companies' consumer-driven plans?

**"A June 2002 Internal Revenue Service ruling ... has sparked interest among employers in Health Reimbursement Arrangement (HRAs)."**

**Defined Contribution**

*Employee Benefits News* regularly covers the many variations in plan design that qualify for the "consumer-driven" label. Jill Elswick writes that, on the road to consumerism, health plans "are now exploring a number of bypasses, side streets, and off-ramps."

Consultant Chase Carey tells Elswick, "It's too soon to be calling an HRA on top of a big-deductible PPO plan the consumer-driven health plan of the future."

Elswick cites several variations on the theme, including "Plan Design Consumerism," in which employers make a defined contribution available and workers can use those funds to pick and choose their own network of physicians, benefits, or cost-sharing.

Each change in the design results in a different total cost of the coverage. Two of the leaders in this model are Vivius, which is working with Health Net, and Choicelinx, which is with Oxford Health Plans and Blue Cross/Blue Shield of Massachusetts.

While such a "building block" approach may give workers "pause to think about the cost implications" at enrollment, they don't affect behavior at "the point of care," according to Definity's Chris Delaney. Lumenos' Doug Kronenberg agrees, noting such plans may sensitize consumers to the cost of coverage, but they don't address the cost of the care itself. It's "kind of tweaking the old system," he explains.

**Consumer Choice Is Goal**

Humana's Beth Bierbower takes a middle-ground position, contending choice is the ultimate goal. "Not everybody is interested, ready, or willing to take a product that's an HRA with a high-deductible on the back end," she says. And while only 6 percent of Humana's employees chose an HRA, Bierbower notes, they all benefitted from the educational tools that were developed to support the HRA option. Humana has seen a "14 percent jump in preventive services, and overall reduction in claims."

Another variation in plan design, according to Elswick's report, is coming from Mutual of Omaha. It will be introducing an HRA featuring separate deductibles for medical (possibly $1,500) and drugs ($200). And Wausau Benefits has developed a product that includes an out-of-pocket deductible before the HRA kicks in.

Finally, CareGain features a "HealthcareIRA," which rolls 25 percent of unused HRA funds into "a portable lifetime medical expense account" but returns the balance to the plan sponsor to help with next year's costs.

Elswick concludes, "Such creative thinking is likely to continue as the notion of consumer-driven health expands into the mainstream."

*Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of* Health Care News. *His email address is* **gmscan@aol.com**.

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# Riding the Wave of Consumerism

## *Not all ideas dubbed "consumer-directed" merit the label*

**Greg Scandlen**

The first annual Consumer Directed Health Care Conference (CDHCC) was held in Las Vegas April 7-9 and was a huge success, with some 700 attendees and 45 exhibitors. Little doubt remains that "consumerism" is the next wave in health care financing and delivery.

The CDHCC delved deeply into case studies to show how consumer-driven care is working out in real life. Yet success brings it own challenges. All kinds of old ideas and products are trying to ride the wave of consumerism—without making any real change.

**Tiered Payment Systems**

This idea started with prescription drug benefits, where health plans would direct patients to lower-cost medications by charging a nominal co-payment for generics, higher for name brands, and still higher for off-formulary drugs. Now some health plans are trying to apply the same principle to hospitals and physicians.

**"All kinds of old ideas and products are trying to ride the wave of consumerism—without making any real change."**

Tiered programs may help some employers lower their costs at the margin, but they are in no sense consumer-directed. Some committee decides who is worthy of getting the lower co-payment and who is not, continuing to divorce the consumer from the true cost of care.

A more consumer-empowering approach would be a system of coinsurance that requires the patient to pay a percentage of the actual fee. Better yet, consumers can be encouraged to apply their own shopping skills with a cash account out of which they pay for health care expenses.

**Evidence-Based Medicine**

Of course medicine should be based on the best available evidence. That is the purpose of medical schools, medical journals, Grand Rounds in hospitals, continuing education programs, peer review, and all the rest. The problem comes in how the information is applied.

There is a movement afoot in the health care industry to develop and enforce "practice protocols." Enforcement would include both carrots and sticks. The carrots include paying more to compliant physicians and exempting them from malpractice disputes. The sticks include dropping non-compliant physicians from networks, paying them less, and in some cases even taking away their license to practice.

The premise of this movement—that some health care professionals somewhere already know the best thing to do in all circumstances—is flawed. They do not. And what they think they know today will often turn out to be wrong tomorrow. It seems every week new research comes along debunking the conventional wisdom of yesterday.

How quickly will the bureaucracy be able to amend its protocols once they are put down on paper and bound there with red tape? And how will the bureaucracy overcome the resistance to change from interests invested in the current protocol?

This sort of evidence-based medicine will quickly become a political boondoggle subject to intense lobbying by some groups wanting the protocol changed and others satisfied with the status quo. Meanwhile, physicians will not be allowed to use their best judgment to treat their own patients.

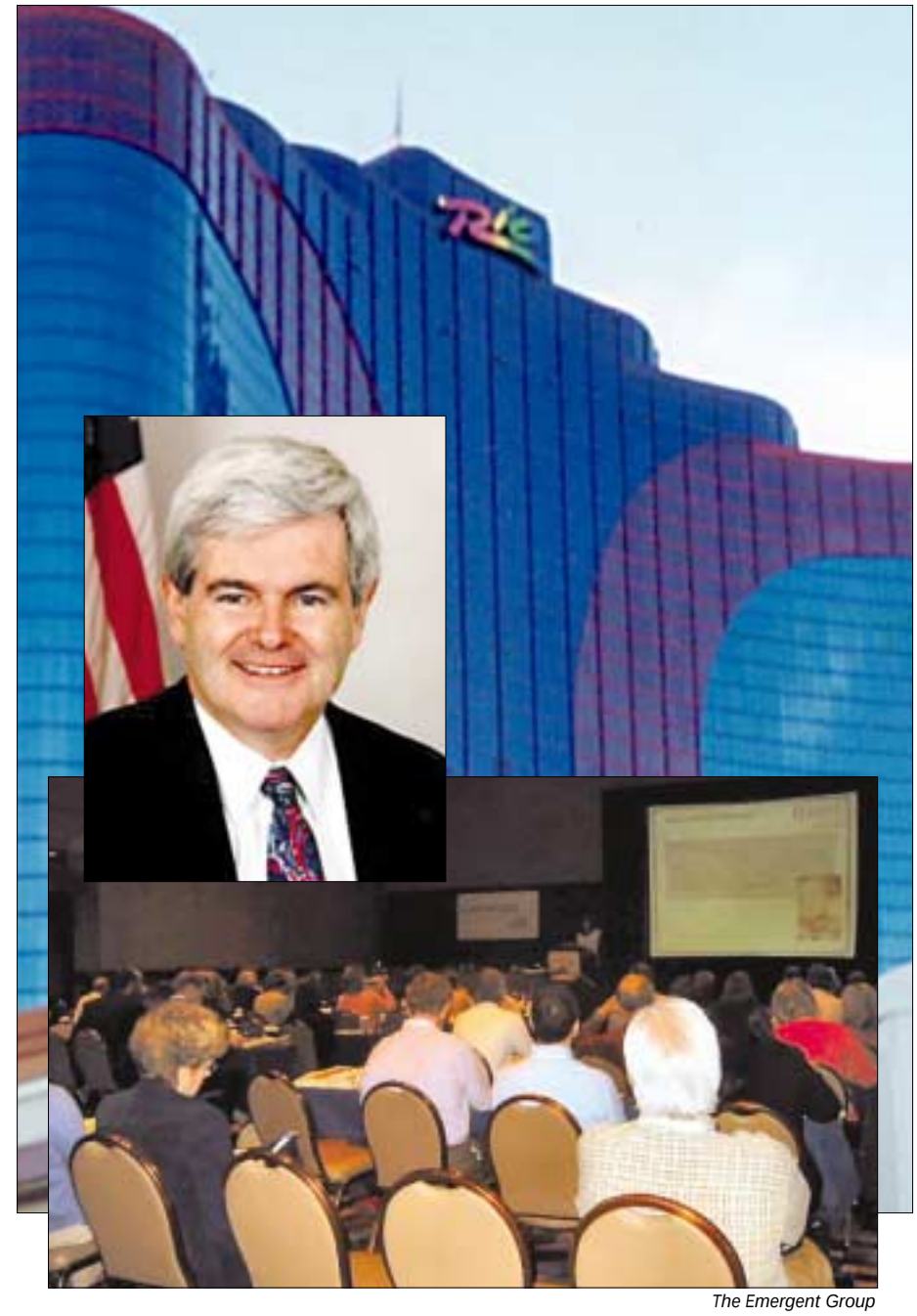
The worst thing about this idea is that it has yet to be debated in any serious way. It represents the worst aspects of the hubris and group-think that characterize much of health policy in the United States.

**Employer Paternalism**

One consultant at the conference described the contortions he went through when a client wanted to cut its health care costs by 15 percent. The employer wanted to cut costs ... but it also wanted to cover all the services it used to cover and impose economizing behaviors on the employees without inconveniencing anyone.

It was like pushing down on a balloon, he said. A push over here would result in the balloon popping up over there.

No one seems to have the nerve to tell employers cutting their costs is the easiest thing around—all they need to do is apply defined contribution. The employer decides how much it wants to spend next year, makes that money available, and lets employees decide what sort of health coverage they want to buy with it. It is not the job of the employer to make these decisions.



*The Emergent Group*

Newt Gingrich spoke live via videoconferencing at this year's innaugural CDHCC event held at the Rio Hotel in Las Vegas.

**Major Strides Made**

Don't get me wrong. The conference itself was great—a major advance in the growth of consumerism in health care. These observations simply highlight how far we have to go.

Almost all of the major vendors were there to highlight their products and marketing strategies, including case studies with major accounts. Plenty of time was spent on information technologies and patient support. There were sessions on how best to educate employees about consumer-directed care, and also on how to apply consumer-directed principles to drug, vision, dental, and alternative medicine benefits.

In some cases, competitors were throwing shots across the bows of their rivals, explaining how their products were superior to others. At the same time there was a lot of networking and commerce going on in the hallways as potential partners sized each other up.

Refreshingly, there was very little politicking. Members of Congress were hardly ever mentioned, legislation was of little concern, few speakers came from Washington, DC. Not a single politician was on the program.

The closest the conference came to hearing from official Washington were the live videoconferences from Newt Gingrich and Mark McClellan. Consumer-driven health care is based solidly in the market, and that in itself is encouraging.

The conference was organized by Skip Brickley and his staff at The Emergent Group. They deserve accolades for putting together a landmark event. Their service to the movement continues in the form of an excellent Web site that includes copies of almost all the presentations delivered at the conference, bios of the speakers, and links to most of the exhibitors.

*Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of* Health Care News. *Please send all comments/questions directly to Scandlen at* **gmscan@aol.com**

**INTERNET INFO**

Much of the content from the first annual Consumer Directed Health Care Conference (CDHCC), held April 7-9, is available on the Internet. Point your Web browser to **http://www.cdhcc.com/old**.

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# Covering the Uninsured:

## HOW STATES CAN EXPAND & IMPROVE HEALTH COVERAGE

**Robert E. Moffit, PhD and Nina Owcharenko**

*Managing Editor's note:*
*The following article summarizes a larger work originally published on March 11, 2003 as Heritage Foundation* Backgrounder #1637.

Innovative governors and legislators in every state of the Union can take specific steps to increase health insurance coverage and improve the range of choice and quality of that coverage for individuals and families.

State officials' range of action is constrained severely by federal law because America's health insurance markets are shaped—and distorted—by the federal tax treatment of health insurance. But while state officials obviously cannot change the federal tax code, they can still take major steps to create more expansive and efficient consumer-based health insurance markets.

**STEP 1:**
**Cooperate with the President in reducing the number of uninsured.**

Over the past two years, the Bush administration has outlined an ambitious and fairly comprehensive health care reform agenda. It includes an $89 billion program of refundable tax credits for the uninsured, an annual rollover of up to $500 of unused funds in employer-based flexible spending accounts (FSAs), and a lifting of existing statutory restrictions on medical savings accounts (MSAs).

**STEP 2:**
**Take a statewide inventory of private plans and design a consumer-friendly information clearinghouse for individuals and businesses on available health plans.**

Individuals and families who do not get health insurance at the place of work or do not have Internet access to health plans often do not know how or where to secure affordable coverage. State officials should break the "awareness barrier" and make that information, including consumer information on quality care, available in an easy and accessible way through agencies that routinely contact working families, such as the motor vehicle administration, the revenue department, or local hospitals.

There is precedent for the provision of consumer information in a consumer-driven health care system at the federal level. The U.S. Office of Personnel Management (OPM) and the personnel offices of all federal agencies provide comparative plan information for federal employees and retirees enrolled in the consumer-driven Federal Employees Health Benefits Program (FEHBP). These enrollees can choose from many private health plans and receive useful comparative information on the available health plans, including premium costs, co-payments, the levels of benefits, and solid comparative information on health plan performance.

**STEP 3:**
**Make sure affordable health plans are available to the uninsured.**

A national online source of health insurance policies, **eHealthInsurance.com**, has reported that the average premium for an individual policy purchased through its Internet service was less than $1,500, with a typical deductible of $500 or less. Studies conducted by the National Association of Health Underwriters (NAHU) and the Health Insurance Association of America (HIAA) report similar findings. HIAA, for example, found that of its members who sell individual policies, the average premium was $2,070 for single coverage and $4,000 for family coverage.

Policy costs vary from state to state, reflecting differing economic conditions, demographics, and patterns of medical practice. However, health plan costs also reflect the cost of state rules and regulations governing individual policies. For example, states impose benefit mandates on individuals and families that purchase health insurance, regardless of whether they want or need such benefits.

In a recent analysis of the factors driving health care costs, Pricewaterhouse-Coopers estimated that, nationwide, government mandates and regulations contributed 15 percent of the total increase in health care premiums for 2001-2002.

Mandated benefits are often popular with provider groups and medical specialty societies, which battle ferociously to make sure state legislators include their treatments or procedures in all state-regulated health plans. Research shows health mandates increase health costs, pricing many individuals and families out of the private market. According to a 1999 HIAA study, as many as one in four of the uninsured are without coverage because of state health benefit mandates.

Some states have begun to change their benefit mandate policies. North Carolina, for example, has imposed a moratorium on any new benefit mandates. Hawaii, Texas, Louisiana, and Vermont require a cost assessment before imposing new benefit mandates. Some states have considered "mandate-lite" plans, and others are taking similar steps.

**STEP 4:**
**Conduct a study of the true cost of the uninsured and use that study to justify state credits or premium subsidies for the uninsured.**

The Texas Comptroller's Office found the total cost of health care spending in 1998 for uninsured Texans was $4.7 billion, including the costs to local governments, doctors, hospitals, and state agencies. In effect, Texas citizens paid about $1,000 that year for health care for each uninsured Texan.

State officials can use this kind of analysis if they wish to expand coverage further and piggyback on any federal health care tax credits or premium subsidies. Additional state assistance, especially targeted at low-income or harder-to-insure individuals and families, would bring the cost of coverage within closer reach of those families.

The Bush administration encourages such assistance. State officials should follow through, especially if they believe the President's proposed federal health care tax credit would not be generous enough for certain populations.

Moreover, for the unemployed, state-based assistance could be administered quickly and easily through state unemployment compensation offices. A person who is eligible for unemployment compensation could automatically be eligible for the credit or the subsidy and for private health insurance. This process of "one-stop shopping" for displaced workers and their families could be done with both a federal and a state credit or premium subsidy approach.

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**STEP 5:**
**Secure HHS waivers to use existing federal funds to expand private health care coverage.**

Officials at the U.S. Department of Health and Human Services have created the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, along with an expedited approval process, "to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and State Children's Health Insurance Program resources (SCHIP)."

HHS officials emphasize the value of "approaches that maximize private health insurance coverage options" and target populations below 200 percent of the federal poverty level. Nationally, a substantial majority of uninsured Americans are below 200 percent of the poverty line. State officials can take advantage of this new demonstration authority and use it to secure innovative private-sector coverage options for low-income, uninsured populations.

Under HIFA, HHS Secretary Tommy Thompson has approved several waivers. New Mexico and Oregon, for example, take advantage of Medicaid and SCHIP funds and combine them with private-sector health plans to expand coverage to the uninsured. In New Mexico, state officials can use unexpended SCHIP funds to subsidize private health insurance for 40,000 low-income residents. Under the New Mexico waiver, employers can also contribute to private health plans.

Based on its waiver, Oregon officials will expand the state's premium support program, the Family Health Insurance Assistance Program, to cover as many as 25,000 beneficiaries. Under the Oregon waiver, Oregon residents earning up to 185 percent of the federal poverty level would be eligible to receive "for the first time" federal premium assistance for employer-sponsored coverage or individual health insurance.

**STEP 6:**
**Improve care for Medicaid enrollees by creating a Medicaid preventive care account.**

The best Medicaid policy gets low-income persons and their families out of the traditional Medicaid program and mainstreams them into the private health insurance market. Meanwhile, states can adopt initiatives that give Medicaid patients more control over their health care spending and decisions while ensuring they get the care they need when they need it.

State Medicaid programs often have a rich benefits package. While Medicaid coverage looks good on paper, however, the program has a well-deserved reputation for perverse economic incentives, disruptions in the continuity of care, and poor quality care.

Faced with exploding Medicaid spending, states are cutting back on benefits, thereby causing a further deterioration in the quality of care. As a recent Kaiser Commission survey of Medicaid directors shows, states are planning cost-cutting measures such as limiting access to prescription drugs and reducing or freezing payments to doctors, hospitals, and other medical professionals.

Most doctors treat Medicaid patients, but they also find Medicaid reimbursement levels are too low and loathe wrestling with Medicaid paperwork and regulations. In 2001, roughly 20 percent of physicians were not accepting new Medicaid patients, and the overall proportion of physicians serving Medicaid patients declined slightly.

The danger, of course, is that Medicaid patients will start to experience difficulty in getting access to doctors and, like the uninsured, will end up either in hospital emergency rooms for routine medical services or, worse, being treated for deteriorating medical conditions that could and should have been treated more effectively if treated much earlier in a doctor's office.

**"Innovative and imaginative governors and state legislators can make significant headway in reducing the number of America's uninsured by expanding choice and competition in the state health insurance markets."**

A partial solution to this problem would be to create a Medicaid preventive care account for each Medicaid recipient with a specified amount accessed using a PIN number and debit card. Payments for routine medical services—doctors' visits, regular checkups, and preventive care—could be paid directly out of the Medicaid account.

For Medicaid enrollees, states could roll the unused funds over each year in an interest-bearing account. When enrollees leave welfare or get a job in the private sector, the unused funds could be used to pay for private health insurance or transferred into a medical savings account or health reimbursement account.

**"State officials should examine the success of such programs in New Jersey, Arkansas, and Florida, where Medicaid recipients decide how best to spend their allocated health care dollars instead of having government officials decide for them."**

State officials should examine the success of such programs in New Jersey, Arkansas, and Florida, where Medicaid recipients decide how best to spend their allocated health care dollars instead of having government officials decide for them.

**STEP 7:**
**Establish a statewide voluntary purchasing cooperative for the uninsured.**

To give residents more coverage options, states should consider designing voluntary purchasing cooperatives that would function much like the FEHBP, which covers Members of Congress, federal workers and retirees, and their families—roughly 9 million Americans.

Unlike other government health care programs, the FEHBP functions with comparatively little bureaucracy and regulation. It also enjoys a solid historical record of cost control, competitive benefits, programmatic stability, and a high degree of patient satisfaction.

**STEP 8:**
**Enact meaningful medical malpractice reform legislation.**

The Bush administration has put the medical malpractice problem front and center in the national policy agenda. This alone is sparking a major debate. But the medical malpractice issue is essentially a matter of state tort law.

There is a medical malpractice crisis in several states. Median jury awards have increased dramatically. Malpractice premiums are soaring, "defensive" medical procedures are common, and patient access to care is being compromised. State legislators can take remedial action. While a sound malpractice reform measure would provide for unlimited economic damages, state legislators can reduce the growing pressures on physicians through several amendments to state tort law.

Several states have made significant progress in reforming medical malpractice laws: Alaska, California, Colorado, Maine, Michigan, and Utah. A sound model for medical malpractice reform would be the Medical Injury Compensation Reform Act (MICRA) of 1975, enacted by the California legislature.

**STEP 9:**
**Take advantage of the new federal health care tax credits to cover workers displaced by international trade.**

In the Trade Adjustment Assistance Reform Act of 2002, Congress enacted a provision to give a 65 percent health care tax credit to the roughly 260,000 workers nationwide who have lost employment and their health care coverage in part because of expanded international trade. The purpose of this first-of-its-kind health care tax credit is to help these workers secure health care coverage.

**STEP 10:**
**Take advantage of the new health reimbursement arrangements for state and municipal employees.**

In June 2002, the U.S. Department of the Treasury ruled America's employers may set aside funds for their employees under a new health reimbursement arrangement (HRA), a special tax-free account for the payment of health bills. Employers may roll over unused funds in the employee's account from year to year and allow employees to use accumulated funds for their health care needs in retirement.

For 2003, the Office of Personnel Management (OPM), the federal agency that runs the FEHBP, allowed the American Postal Workers Union (APWU) health plan to offer an HRA to federal employees and retirees. Under the APWU plan, federal employees can get an up-front credit of $1,000 per person or $2,000 per family in their account to pay for traditional medical expenses as well as dental, vision, and other expenses that may not be covered by insurance. The funds are available before enrollees pay deductibles or out-of-pocket costs, and traditional insurance covers their health costs.

**STEP 11:**
**Engage faith-based organizations in preventive care and wellness programs.**

State and local officials manage or oversee public health clinics and health centers. These organizations help low-income and uninsured families secure health care services.

An enormous resource exists among faith-based and religious organizations. These organizations can play a vigorous role in promoting and sponsoring wellness and preventive care programs. State officials should make every effort to tap the power of faith-based and religious organizations in their health care outreach into various communities, particularly inner-city and ethnic communities. They should also find ways of integrating these faith-based wellness initiatives into their public assistance programs.

**Conclusion**

Innovative and imaginative governors and state legislators can make significant headway in reducing the number of America's uninsured by expanding choice and competition in the state health insurance markets.

The problems of the uninsured are problems for federal and state officials. While the central weakness of the health insurance market is the inefficient, inequitable, and restrictive federal tax treatment of health insurance, state officials can nonetheless take direct action without waiting for Congress to enact major changes in the federal tax code.

States can work energetically with the administration and also implement innovative solutions on their own. Millions of Americans desperately need that federal-state cooperation.

*Robert E. Moffit PhD is director of the Center for Health Policy Studies, and Nina Owcharenko is health care policy analyst, at The Heritage Foundation. For the complete analysis with footnotes, visit the Heritage Web site at* **http://www.heritage.org/Research/HealthCare/bg1637.cfm**.

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# How Many Americans Are Uninsured ... and for How Long?

**Conrad F. Meier**

The figure most often cited as an estimate of the number of uninsured Americans—41 million—may be over-stated by 10 to 20 million, according to the Congressional Budget Office (CBO). Many experts fear policymakers relying on the wrong data could improperly reshape our health care system, leading us to a one-size-fits-no-one single-payer health care plan.

After reviewing data from several sources, the nonpartisan CBO estimates 21 to 31 million Americans go without health insurance for 12 months or more. At least 59 million may be uninsured at least briefly in a given year, the report concluded. (See "Advocacy Groups Inflate Number of Uninsured," *Health Care News*, May 2003.)

**Moving Target**

Douglas Holtz-Eakin, director of the CBO, explained, "There are two problems, short spells and long-term uninsurance. There is no such thing as the typical uninsured."

The commonly cited estimate of 41 million uninsured comes from the Census Bureau's Current Population Survey (CPS) and is based on a large national sample, not an actual head count.

Data from three federally sponsored national surveys—the Survey of Income and Program Participation (SIPP), the Medical Expenditure Panel Survey (MEPS), and the National Health Interview Survey (NHIS)—provide estimates of the number of uninsured at a particular point in time. All three agree that at a specific point in time during the year, roughly 41 million Americans are uninsured.

**"Far from being a static group, the uninsured population is constantly changing."**

But SIPP and MEPS data show a far smaller number—21 to 31 million people—are uninsured for an entire year. (See graph.)

A third measure of the uninsured is the number of people who lack insurance at any time during the year. At around 59 million, the figure includes people who are uninsured for only part of the year plus those uninsured throughout the year.

About 30 percent of non-elderly people who become uninsured in a given year remain so for more than 12 months. Nearly 50 percent regain health insurance within four months. Long uninsured spells occur less frequently than do short spells.

**Prone to Error**

Population surveys are prone to reporting and statistical errors, and the data derived from them are inherently unreliable. Controversy regularly attends reports from the decennial Census Bureau surveys for exactly that reason.

Some segments of the population may be under-represented in surveys, leading to the possibility of an undercount of the number of uninsured. Over-stating is also a possibility, if estimates are extrapolated from samples that are too small or insufficiently representative of the population as a whole.

Even when populations are properly surveyed, their answers may not be accurate. Misstatements, intentional or not, plague population surveys.

Researchers who compared data from the Centers for Medicare and Medicaid Services with the Center for Disease Control's monthly Behavioral Risk Factor Surveillance Study concluded, for example, that some Medicaid recipients will say they don't have insurance coverage, when in fact they do.

There is evidence respondents to surveys about insurance coverage do not count government-provided health plans as insurance. The perception is understandable: Persons covered by such insurance pay no premiums, make little or no co-payments for care, and receive no evidence of having an insurance policy.

Moreover, some people counted among the uninsured are eligible for insurance—Medicaid and the State Children's Health Insurance Programs, for example—but have not applied. Some are unaware those programs exist.

Some policymakers believe such people should be regarded as insured, because they can apply for Medicaid when they need it and can receive retroactive coverage for their expenses. Others believe such people should be regarded as uninsured because they do not use Medicaid for their routine medical care. In any event, passing a new government insurance program is unlikely to make a difference for these "uninsured."

**Uninsured Still Have Access**

Roughly 9 million documented and undocumented aliens are generally included in the uninsured estimates. Many of them have access to the private health care system, some without paying at all or by paying cash in an effort to remain anonymous. Many hesitate to participate in a government-program that could establish a paper trail for immigration authorities. Cultural mores, folkways, and language barriers also conspire to keep these people uninsured.

Persons without insurance or the cash to pay for care may have insufficient access to the most appropriate care, and they may be exposed to significant financial risk when they do get care. Nevertheless, they are not without access. Public and private hospitals, community health centers, local health departments, free clinics, faith-based programs, emergency rooms, and Department of Veterans Affairs facilities provide billions of dollars' worth of care to the uninsured every year.

**Policy Implications**

Far from being a static group, the uninsured population is constantly changing. Some people are uninsured for long periods, but more are without coverage for shorter periods: when they are between jobs, graduating from college, or being discharged from military service.

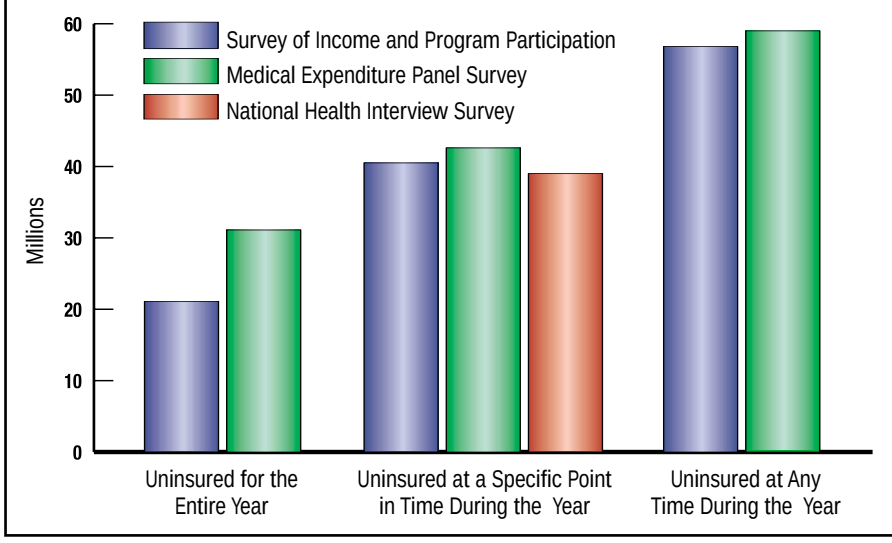
Health care reform policies aimed at reducing the uninsured rate are most likely to be effective if they take into account the different implications of short-term and long-term periods of uninsurance and the different reasons for being uninsured.

To aid people with short uninsured spells, appropriate policies might include time-limited premium support for private temporary health insurance plans, aimed at filling a temporary gap in coverage or preventing a gap from occurring.

To assist those who go for longer periods without insurance, appropriate policies might provide or facilitate an ongoing source of coverage, such as continuing premium support or tax credits for portable medical savings accounts.

*Conrad F. Meier is managing editor of* Health Care News. *His email address is* **meier@heartland.org**.

**Estimated Number of Nonelderly People Without Health Insurance in 1998**




Source: Congressional Budget Office.

Note: The Centers for Disease Control and Prevention, which sponsors the NHIS, reports only the point-in-time estimate.

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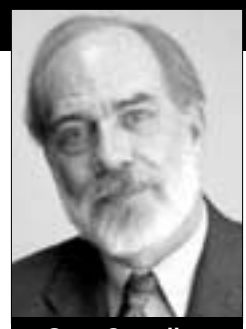

Greg Scandlen

# Singularly Unimpressed with Single-Payer

James G. Knight MD, president of the San Diego Medical Society, has an observation or two in the *San Diego Union Tribune* about all the health care reform frenzy.

Knight says one of the jobs of a doctor is to tell you what you don't want to hear: "So here it is: No one can afford to give you everything you want for free, forever. That is especially true for quality health care." While most Americans now consider health care a "right," Knight adds, "85 percent of Americans want nothing to do with paying for their own care."

"How can something be that important, yet not be worth paying for?" he asks. He goes on to say the reason there are so many uninsured is because insurance has become so expensive, and the reason insurance is so expensive is because most people get their care for free, or for a $5 copay.

**"No one can afford to give you everything you want for free, forever. That is especially true for quality health care."**

Knight is unimpressed with the current raft of universal health care proposals. "Can California, currently facing a $35 billion deficit, be relied upon to responsibly run a massive new system that will be the sole provider for 30 million Californians?"

"It's time to put the consumer back in the game," according to Knight. "American consumers must be empowered to take control of health care." He says "the growing national trend toward 'consumer directed health care' is a practical and immediate necessity," and urges legislators to confine themselves to making sure there is a truly competitive marketplace.

The article ran April 13, 2003. You may search the archives for a free abstract or purchase the complete text at **http://pqasb.pqarchiver.com/ sandiego/**.

**The Case for Consumer-Driven Health Care**

Writing in the May/June issue of *Contingencies*, Definity's head actuary David Tuomala makes "The Case for Consumer-Driven Health Care." He says reform efforts in that direction are "an attempt to build a more rational model in health care." He disagrees with those who "suggest that health care is fundamentally different from other parts of the economy, and that the usual supply and demand considerations don't apply."

Instead, the key transaction occurs between a provider of care and a patient. This is where supply and demand plays out, he notes, and this is where attempts at third-party control break down. He contends consumer-driven models such as "personal care accounts" that require a financial transaction at the point of care will be more effective than defined contribution approaches that require consumer judgment only at the time of enrollment.

Tuomala uses the vision care system as an illustration of a point-of-care payment system. He says the system tends to be highly competitive, price transparent, and convenient for consumers. "Even when expensive new technology (such as lasik surgery) becomes available, a different pattern emerges than elsewhere in health care," with prices dropping over time.

Tuomala adds, "Many of the problems we face in health care today can be traced to the prevalence of the third-party payment system itself."

*Source*: **http://www.contingencies.org/mayjun03/ commentary.pdf**

**Bringing it Home in Arkansas**

The *Arkansas Democrat-Gazette* explains how consumerism is beginning to affect The Natural State. Arkansas is currently "studying a plan for the state's 31,000 employees and retirees and its 45,000 school employees and retirees," according to Sharon Dickerson of the Department of Finance and Administration.

Michael Taylor, a Towers Perrin consultant, says employees "have to realize that this is their money they're spending and not a third party's." The article quotes Cato's Tom Miller as predicting consumer-driven plans will provide premiums of "between 5 percent to 10 percent lower than rates offered by traditional managed care."

Tom Liskey, who reported the story, says the concept may be "relatively new to the health care industry," but it is "as simple as seeing the price tag before making a purchase." The "starting point is the consumer," he writes, and only when consumers get interested in price will providers start to reveal what their prices are.

John Goodman of the National Center for Policy Analysis is also quoted, saying "If patients are footing the bill, providers are going to have to be more forthcoming in their prices." That, in turn, will develop a competitive impulse to lower prices.

*Source*: **http://www.ardemgaz.com/**. *The article ran in the business section on Sunday, April 20, 2003. The paper charges for archives.*

**Market Expansion in Florida ...**

The *Orlando Business Journal* reports Humana is re-entering Florida's individual market, and Aetna is considering doing so as well. Reporter Christine Sexton says Blue Cross and Blue Shield of Florida and United have been the only carriers providing individual coverage until now.

The article quotes a Humana spokeswoman as saying, "We're full service. Now we have a complete product line for Florida." An Aetna spokeswoman says they consider Florida an attractive market and "are currently exploring possible product offerings that would provide additional choices for Florida's uninsured residents." There are currently 3 million uninsured in Florida and 600,000 enrollees in individual insurance products.

*Source*: **http://orlando.bizjournals.com/orlando/stories/2003/ 03/31/daily54.html**

**... and in DC**

The insurance commissioner of Washington DC, Lawrence Mirel, is developing a proposal that would build on the individual insurance model, according to the *Washington Business Journal*. His "Equal Access to Health Insurance Act" would use an FEHBP-type structure to enable Washington residents and employees to purchase their own coverage. The program also would include a Risk Transfer Plan to reinsure participating carriers for excess losses. It isn't clear whether the program would include any coverage subsidies, though the reinsurance program could make an elegant pipeline for any subsidy.

*Source*: **http://www.washington.bizjournals.com/ washington/stories/2003/04/21/story4.html**

**Tufts Committed to Consumer-Driven Plan**

Meanwhile, the *Boston Globe* reports Tufts Health Plan is solidly committed to a consumer-driven model. Reporter Charles Stein quotes Tufts Senior Vice President Jon Kingsdale as saying, "I think potentially what we are talking about is as radical an innovation as HMOs were 30 years ago."

Tufts will cover hospital care and drugs for chronic conditions, but use an MSA-type arrangement for more discretionary spending. The article notes the product design is taken from South Africa's Discovery (and its American affiliate Destiny) and says company president Adrian Gore "has reams of charts that show his plan slows the growth of health spending but doesn't discourage people from seeking preventive care. Compared to people covered by traditional insurance, Gore's customers spend less on dermatology, drugs and physical therapy but get more Pap smears, mammograms, and cholesterol screenings."

*Source: The article was published on May 25, 2003. There is a fee for accessing it through the archives at* **http://www.globe.com** *but I'll wager that Mr. Stein would send it to you if you e-mail him at* **stein@globe.com**.

**Also in Boston**

Mary Pratt writes employers are responding to rising health costs in a number of ways. "Some employers are passing on more of the rising costs to employees, while others are dropping the level of benefits being offered in order to keep costs in check. And a relatively small number are adopting a plan model designed to expose employees to the true cost of care."

She cites a local broker who had "three clients purchase new consumer-driven plans, which tout savings of about 15 percent for employers." She adds, "Many of the major health insurance companies have either introduced or are now rolling out versions of these plans to help employers cope with the escalating premiums."

*Source*: **http://boston.bizjournals.com/boston/stories/ 2003/05/26/focus1.html**

*Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of* Health Care News. *His email address is* **gmscan@aol.com**.

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# Rx Bill

**Continued from page 1**

leaves our seniors at risk of serious illnesses, disease and injuries, all of which Medicare would pay to treat after the fact.

"Medicine is changing," Bush said, referring to the increasing use of prescription drugs to address ailments before they become life-threatening or require hospitalization. "Medicare is not." Bush wants Congress to have a reform package complete before its Fourth of July break.

But reform experts warn the agreement is disturbingly short on details. "On Tuesday night [two days before the Finance Committee vote], the Senate received a 70-page outline of the bipartisan compromise Medicare prescription drug plan," writes Jane Orient MD, president of the Association of American Physicians and Surgeons (AAPS). "But let me emphasize *outline*, because the specific language of the bill has not been finalized."

"It is an utter disaster," says Stuart Butler, vice president for domestic and economic policy studies at The Heritage Foundation.

"Despite the rhetoric, it is not reform," he warned. "It does not create new private plans and choice—it will reduce existing private plans and choice. This legislation will undermine the health system and impose trillions of dollars in financial burdens on future generations to solve a short-term political problem and a very limited health need that could be addressed easily and inexpensively."

The National Association of Health Underwriters (NAHU), representing more than 18,000 professional health insurance agents and brokers disagreed, praising the bill in a June 10 news release. "The Prescription Drug and Medicare Improvement Act of 2003 will provide seniors with more health care choices, better benefits, and better access to the latest innovative medical practices and treatments," it noted.

**Prescription Drug Coverage**

The centerpiece of the measure—"and the thing they most want to pass," notes Merrill Matthews Jr., Ph.D., director of the Council for Affordable Health Insurance (CAHI)—is the prescription drug benefit.

Under the measure, beneficiaries who remain in government-run Medicare would pay a $275 deductible and $35 monthly premium for the drug benefit. Participating private health plans could set premiums higher or lower than $35 per month, but the prescription drug coverage they offer must be equivalent to that offered under Medicare.

Beneficiaries would be required to pay half of their annual prescription drug costs between $276 and $3,450, and all drug costs between $3,451 and $5,300. After $5,300, beneficiaries would be required to cover 10 percent, and Medicare would cover the rest.

The new plan would take effect in 2006. Until then, the federal government would authorize the use of drug discount cards in 2004 to help Medicare beneficiaries save money, and low-income beneficiaries would be eligible for a $600-a-year drug benefit in 2004 and 2005.

While the proposal may sound attractive, warns Matthews, it's not workable. "The Senate plan envisions private insurers offering the prescription drug insurance policies. But currently there is virtually no stand-alone prescription drug coverage being sold in the country, because insurers have always lost money on these plans. The Senate is passing legislation so that seniors can choose from plans that don't exist."

Twila Brase, president of the Citizens' Council on Health Care, warns seniors they "should not rush to embrace" the Finance Committee's proposal.

"This is drug coverage by committee. A bureaucratic process will determine which drugs are available and who gets them. Not every medication will be covered, covered medications can be denied, and private drug coverage may no longer be available," she notes.

**"This is drug coverage by committee. A bureaucratic process will determine which drugs are available and who gets them. Not every medication will be covered, covered medications can be denied, and private drug coverage may no longer be available."**

**TWILA BRASE, PRESIDENT**
**CITIZENS' COUNCIL ON HEALTH CARE**

**Medicare Advantage**

The committee's plan also calls for a new type of insurance coverage, called "Medicare Advantage." Private plans would offer coverage for catastrophic health expenses and preventive care, giving beneficiaries an incentive to move out of traditional Medicare and into a private plan.

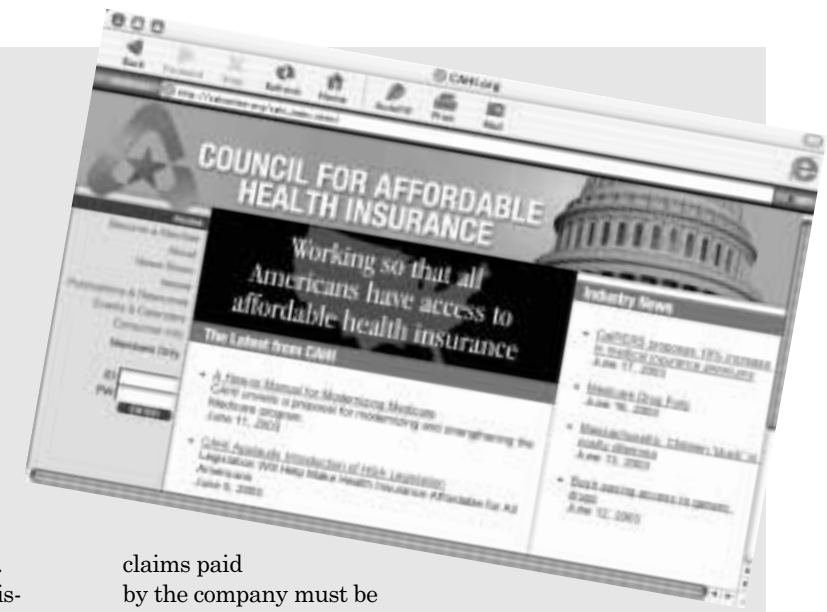
Janet Trautwein, vice president of government affairs for NAHU, expressed the group's support for the bill. "We're pleased that the legislation removes some of the disincentives for carriers to participate in the program and encourages new private plans, which will bolster plan participation, providing better coverage to more seniors."

Under the plan, beneficiaries opting for private coverage would pay a $400 deductible for hospital and doctor visits, compared with $840 for hospital stays and $100 for doctor visits for beneficiaries remaining in traditional Medicare.

"Medicare must change," writes Tom Miller, director of health policy studies at the Cato Institute. "Opening up its coverage options to emphasize a greater role for private sector health plans could offer at least a flicker of market-based candlelight to help lead us out of the fiscal tunnel ahead."

AAPS's Orient, however, doubts the plan will attract Medicare beneficiaries into private coverage.

# CAHI Releases Medicare Reform "How-To" Manual




**Tom Gardner**

To be successful, any plan intended to provide senior citizens on Medicare with more private-sector health insurance options must be attractive to insurers, or none will participate.

In an effort to provide Congress and the Bush administration with guidance on how to address such issues as health plan accountability, financial solvency, access, and pricing, the Council for Affordable Health Insurance (CAHI) enlisted the help of actuaries and insurance and health policy experts to produce "A How-To Manual for Modernizing Medicare," unveiled on June 11.

Critics of private-sector options worry private companies will mishandle funds or commit accounting fraud. How can consumers be protected? Here are some of the answers.

**Plan Status and Solvency**

- States already monitor insurers' compliance with accounting standards and their financial status. State-required reports should be copied to the federal government so that a federal agency is informed of the plans' status.
- Many states have established a guarantee fund association, regulated by each state's department of insurance, to protect consumers against insurer insolvency. Insurers offering private Medicare plans should be required to participate in a guarantee fund in those states where they sell Medicare policies.

**Policy Cost**

- One of the first complaints about private plans will be that insurers will charge seniors premiums that are too high. Fortunately, there is an easy way to guarantee insurers charge only what they need to cover losses, plus administrative costs: a minimum-loss ratio, which says claims paid by the company must be equal to a certain percentage of the premium taken in (e.g., the claims paid must be at least 65 percent of premium received). That model is supported by the National Association of Insurance Commissioners and is already working in many states.

"The key to giving seniors more choices is to ensure that lots of private insurers participate in Medicare," said Dr. Merrill Matthews Jr., Ph.D., director of CAHI. "The 'How-To Manual' provides a blueprint for how to modernize Medicare and highlights what states are already doing to address some of the most difficult issues."

The Alexandria, Virginia-based CAHI is a research and advocacy association of insurance carriers active in the individual, small group, medical savings account, and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries, and insurance brokers.

*Tom Gardner is director of communications for CAHI. He can be reached by phone at 703/836-6200, extension 386, or by email at* **tgardner@cahi.org**.

**INTERNET INFO**

CAHI's "How-To Manual for Modernizing Medicare" is available on the Internet at **http://www.cahi.org**. Or call 703/836-6200.

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"Since we don't know the details yet," she writes, "we can't comment on the merits.

"But what we do know so far is that the bill would create a universal government plan that would act as a floor, rather than ceiling, for private plans. That means lower-cost private plans that offer basic coverage would no longer be allowed to do so—they would have to match the government plan, giving seniors little or no choice of type of plans to choose.

"This means we can expect a massive exodus as people bail out of private coverage they now hold and run to the taxpayer-funded entitlement instead."

Cato Institute Senior Fellow Alan Reynolds agrees. "Both Republicans and Democrats are threatening to 'reform' Medicare by greatly increasing future subsidies, and thus increasing future Medicare taxes," he wrote in March. "The problem ... is that its 10-year cost is $400 billion, which is $400 billion too much."

**Administration May Compromise**

Although Bush and other Republicans would prefer a reform proposal offering a bigger drug benefit in the private plan option, in order to encourage seniors to join such plans, an administration official told *Health Care News* the Finance Committee plan represents "breakthrough" progress and should attract bipartisan support in the Senate.

CAHI's Matthews expressed dismay at the administration's eagerness to compromise on a flawed bill.

"The administration had it exactly right in its original Medicare outline program, covering only the lowest-income and highest-cost users for those who remained in traditional Medicare. But the administration doesn't want to be opposing the efforts of a good Senate Republican, Sen. Grassley."

**"I think the process is perilously close to dropping all of the reform and restructure portions and settling for a prescription drug benefit. That may be good politics in the short run, but terrible policy in the long run."**

**MERRILL MATTHEWS JR., PH.D., DIRECTOR**
**COUNCIL FOR AFFORDABLE HEALTH INSURANCE**

The *New York Times* has suggested Bush would sign "almost any bill that emerges from the Republican-controlled Congress." That's unfortunate, notes Matthews, because "the Senate bill is almost completely a result of political compromise rather than trying to craft good policy."

**Stumbling Blocks Remain**

Senate Minority Leader Tom Daschle (D-South Dakota) said the Finance Committee's plan "falls significantly short" of Democrats' goals for Medicare reform. Daschle said Democrats do not favor a plan that has a gap in drug coverage, allows insurance companies to set prices, or does not guarantee equal access for beneficiaries in rural areas.

Some Democrats said the Finance Committee proposal does not include enough details for them to offer their support. Senator Kent Conrad (D-North Dakota) told CongressDaily/AM, "It's appalling—this would be one of the most important bills we could vote on, and the Finance Committee is playing hide-the-ball."

Nevertheless, writes Morton Kondracke in his "Pennsylvania Avenue" column in *Roll Call*, it appears "the long war" between Democrats and Republicans over a Medicare drug benefit might be coming to a close.

"Although there are still 'stumbling blocks' to an agreement—particularly the Bush administration's insistence on offering more extensive drug benefits to those beneficiaries who join private plans—it appears as if Democrats and Republicans are nearing a deal under which Republicans could craft reforms based on private coverage as long as all beneficiaries receive the same drug benefit."

Kondracke cautions, "The danger would be in delay. The nearer Congress gets to an election year without passing [a Medicare drug] benefit, the more politicians will be tempted to exploit it as a [campaign] issue one last time."

Matthews of CAHI, however, sees little reason to move quickly on such a flawed proposal.

"The administration's initial goal was to fundamentally restructure the culture of Medicare—which is convoluted, hard-to-understand health insurance in a system that is going bankrupt—but to use the prescription drug benefit as the bargaining chip to get Democrats to agree.

"I think the process is perilously close to dropping all of the reform and restructure portions and settling for a prescription drug benefit. That may be good politics in the short run, but terrible policy in the long run."

Cato's Miller agrees. "This year's Medicare debate promises us only the appearance of 'MINO' reform—that is, Market-based In Name Only. It tastes bad, and it's certainly not filling."

*Conrad F. Meier is managing editor, and Diane Carol Bast is editor, of* Health Care News. *Meier's email address is* **meier@heartland.org**.


# Looking for an outstanding speaker?

## Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economists, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

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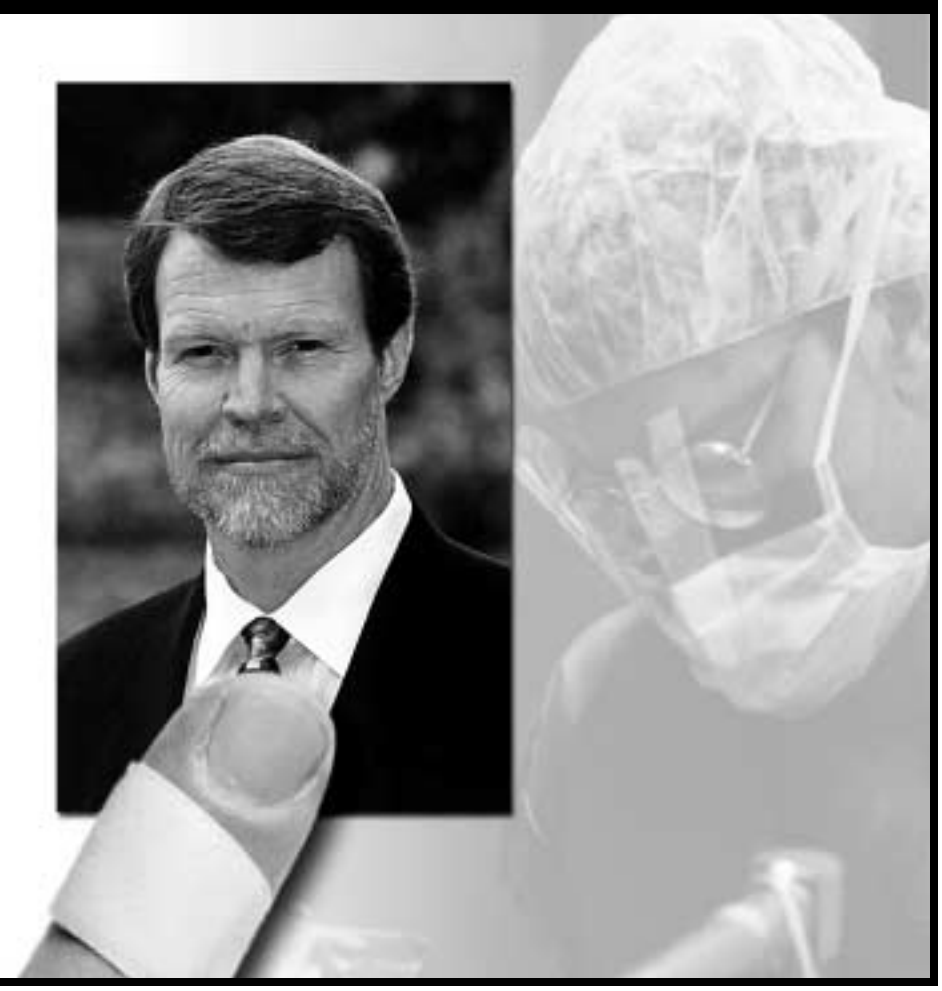


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# Britain's Blair Supports Private-sector Health Care

**Conrad F. Meier**

British Prime Minister Tony Blair is backing away from his country's decades-old socialized health care model, following the lead of Sweden, which has launched a revolutionary move away from single-payer and toward a blended private-sector and public-sector health care model. (See "Choice in Europe," *Health Care News*, May 2003.)

On June 13, Dr. John Reid replaced Alan Milburn as Britain's health secretary. Milburn, who left his position for family reasons, believed years of central control over the National Health Service (NHS) wasn't working. Reid appears to be cut from similar cloth—"an arch-reformer of the Blairite school," according to Dr. Eamonn Butler of the U.K.-based Adam Smith Institute.

At a recent breakfast meeting at 10 Downing Street, Blair told private-sector health care executives he wants to open the British health care system to outside competition. His comments are expected to accelerate reform of the NHS and squelch the Labour Party's rebellion against creating privatized hospitals. Under Blair's proposal, NHS would no longer be micro-managed by the central government.

The breakfast was attended by representatives of private companies bidding to run 11 diagnostic and treatment centers (DTCs) scheduled to open this December. The new private DTCs would cut through the government bureaucracy and waiting lines to provide fast-track hip replacement and cataract surgery for NHS patients. They are expected to perform about 100,000 operations a year.

According to London media reports, Blair told the group, "We are anxious to ensure that this is the start of opening up the whole of the NHS supply system so that we end up with a situation where the state is the enabler, it is the regulator, but it is not always the provider. The basic principles of the NHS will remain, but we will operate them and implement them in a different way."

**Controversy Remains**

"Unfortunately, this is a half-hearted reform," warns the Adam Smith Institute's Butler. "These hospitals will still be NHS hospitals, and have no real power to borrow (except from the Treasury) or determine their own pay, conditions, or staffing. They are a step in the right direction, but a very faltering step.

"And of course hospitals are only a small part of the NHS. Ninety percent of patient contact with the NHS is with family doctors or pharmacists—and they are strained to the breaking point because of the regulation, paperwork, and targets the government has set for them."

British officials were not uniformly supportive of Blair's plan. David Hinchliffe, the liberal Labour chairman of the Commons health select committee, said Committee members could find no substantial evidence that private companies offered the NHS anything that could not be achieved by the public sector.

Butler disagrees.

"What we need are independent, profit-making or non-profit hospitals, willing to take on NHS cases that are paid for by the government. There's nothing earth-shaking about this: we already send patients to French and Swedish hospitals in order to reduce the backlog of cases here. Old Labour supporters are against this 'privatization,' but it would open up the market for health care while still ensuring that those who need treatment are paid for by the state. The Conservatives are proposing a 'passport'—really a voucher—system that would do just this."

The potential private-sector health care provider companies include Netcare, the largest integrated health care company in South Africa, and a host of companies from the United States, Canada, Germany, France, and Switzerland. The companies would bring their own clinical staff, to avoid exacerbating NHS staff shortages. Moreover, in an effort to prevent "poaching" doctors and nurses from developing countries, the British health department has promised it would not go ahead without the blessing of the South African government.

"Politically, it is impossible to privatize the NHS overnight," admits Butler. "But it's certainly possible to open up the market to a mixture of public and private provision, and public and private payment, just as it is everywhere else in the world. I think we should give people the taste of freedom, and we will soon find them demanding more."

*Conrad F. Meier is managing editor of* Health Care News. *His email address is* **meier@heartland.org**.

# *Spiers Offers Consumer-Driven Plan for Britain*

**Melissa Davis**

On June 19, the U.K.-based Institute for Economic Affairs hosted a "book launch" dinner for *Patients, Power and Responsibility: The First Principles of Consumer-driven Reform*, by Professor John Spiers of the University of Glamorgan. Published by Radcliffe Medical Press in association with the IEA, the book describes Britain's need for a more consumer-directed health care system.

The Labour Party, says Spiers, "seeks to spend its way to security. This can improve capacity, but without direct incentives and competition we will never attain European levels of quality care."

Individual responsibility drives both good health care and good personal health, Spiers notes. He sets forth the broad outlines of a more consumer-directed health care package. Among them:

- To achieve both patient empowerment and individual self-responsibility (for own care; for the consequences of our behaviour; for choice) every patient should be given control over a personal fund of cash for medical expenses, in voucher form.
- Every adult would become a Patient Fund Holder. The government would mandate a "core" package of health care—Patient Guaranteed Care, or "Pretty Good Care"—for which the funds would pay.
- The core package would be legally enforceable. Under the current system, patients have no legal leverage to ensure timely and appropriate access to care.
- The government's principal role in the system would be to ensure incentives, choice, and competition work. Without these, no progress is likely.
- To ensure the system has political legitimacy and change is politically persuasive, a new approach must achieve equality of access, higher quality and greater capacity of service, improved professional pay and morale, and enhanced funding by allowing individuals to pay more for better coverage.

*Melissa Davis is communications director for the Institute for Economic Affairs. Her email address is* **mdavis@iea.org.uk**.

**INTERNET INFO**

*Patients, Power and Responsibility: The First Principles of Consumer-driven Reform* can be ordered from Radcliffe Medical Press at **http://www.radcliffe-oxford.com**. More information on the Institute for Economic Affairs is available at **http://www.iea.org.uk**.

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A MONTHLY REVIEW OF HEALTH POLICY MATTERS

Grace-Marie Turner

A Washington Post/ABC News poll reported the American people trust President George W. Bush, by a 55 to 37 percent ratio, to handle the major problems facing Americans ... except health care. The poll reported 57 percent of them disapprove, and only 34 percent approve, of the way Bush is handling the "cost, availability, and coverage of health insurance."

The problems facing the U.S. health care system have deep and complex roots and will not be solved by next year. Change does not come easily when 45 percent of the nation's health care is financed through government programs and the remaining 55 percent is heavily burdened by federal and state benefit and procedural mandates.

The main legislative initiative to help some of the uninsured keep or get coverage—the refundable tax credits contained in the Trade Adjustment Act of 2002—will be an important start. Yet they also are extraordinarily complex to implement, and only 250,000 to 500,000 people will be eligible. The Bush administration is determined to make the tax credits work and to expand—and improve—the program to cover millions more of the uninsured.

A recent briefing sponsored by the Healthcare Leadership Council provided insights into the heroic efforts to make tax credits work by officials at Treasury, Health & Human Services, Labor, and the Internal Revenue Service, plus outside groups like the National Association of Health Underwriters, the Lewin Group, and others.

These smart people are working very hard to create the necessary financial infrastructure and to help the states create purchasing options to meet the August 2003 deadline.

It's never easy to create new free-market options within the regulatory morass of the health care system, but these smart and dedicated people are doing it. It's an important start, but the credits need to be made available to millions more of the uninsured—and soon—to begin to energize the private market for health insurance.

**"It's never easy to create new free-market options within the regulatory morass of the health care system, but these smart and dedicated people are doing it."**

That, coupled with the creativity of employers in structuring consumer-directed health care options, can begin to turn things around ... and not a moment too soon!

**— Grace-Marie-Turner**

# RECENT ARTICLES & STUDIES

**Washington and the States**
*Michael S. Greve*
*American Enterprise Institute*
*April 24, 2003*

Michael Greve of the American Enterprise Institute says the fiscal crisis facing many states is not a revenue crisis, as the National Governors Association asserts. Rather, he says, it is a systemic problem plaguing "cooperative" federalism: States cannot turn down federal matching funds, and thus they increase spending in times of economic prosperity. In Medicaid, this means states expanded optional benefits and eligibility in the 1990s beyond what would be sustainable in slower economic times.

Instead of giving states more money, Greve suggests separating federal and state functions by having the federal government take over long-term care and prescription drugs in exchange for caps on all other federal payments to states for Medicaid.

*Source*: **www.aei.org/publications/pubID.17053/pub_detail.asp**

**Lifetime Social Security and Medicare Benefits**
*Eugene Steuerle and Adam Carasso*
*Urban Institute, March 2003*

Eugene Steuerle and Adam Carasso of the Urban Institute examine the value of lifetime Social Security and Medicare benefits promised under current law. They argue "a lifetime approach reflects both the growth in annual costs and number of years of benefit receipt [which] gives the most comprehensive picture of what government is being asked to provide."

The authors find the value of lifetime Medicare benefits for an average-wage worker and low-wage spouse would be $490,000 if they retired in 2030. But the couple will have paid only about one-fifth that amount in payroll taxes over their lifetime.

"While a shifting of tax burdens to future generations is possible for a very long time, it is not sustainable—hence the call for reform," conclude Steuerle and Carasso.

*Source*: **www.urban.org/urlprint.cfm?ID=8356**

An analysis of the 2003 Medicare Trustees Report by Matt Moore of the National Center for Policy Analysis also discourages the concept of intergenerational transfer. "When today's workers retire, their benefits will be paid only if the next generation of workers agrees to pay even higher taxes," writes Moore.

*Source*: **www.ncpa.org/pub/ba/ba436**

**Medicare Reform, French Style**
*Robert Goldberg*
*The Washington Times*
*April 30, 2003*

Tom Scully, director of the Centers for Medicare and Medicaid Services (CMS), could hinder President Bush's plan to improve Medicare because "rather than finding important ways to move Medicare into the marketplace, he is adopting the French method of cost containment called reference pricing," says the Manhattan Institute's Robert Goldberg.

Scully's method of "functional equivalence" extends rationing and price controls to prescription drugs. "But in the weird science of Mr. Scully's 'functional equivalence,' lawyers, not doctors, lobbyists, not scientists, politicians, not patients, determine what drugs are used and paid for," says Goldberg.

*Source*: **www.washingtontimes.com/op-ed/20030430-4497420.htm**

**A New Consensus for NHS Reform**
*UK Health Policy Consensus Group*
*May 2, 2003*

The UK Consensus Group, consisting of experts from prominent Labour Party members to representatives of market-oriented think tanks, has issued its final report on how best to reform the British National Health Service.

The group recommends four possible funding solutions: 1) evolutionary reform of primary care trusts; 2) a tax-funded core service with treatment vouchers and top-up insurance; 3) social insurance with individual payment; and 4) social insurance with consumer health purchasing cooperatives, modeled after the U.S. Federal Employees Health Benefits Program.

The group also recommends converting all government-owned hospitals into independent foundation hospitals "at the earliest possible date."

*Source*: **www.civitas.org.uk/nhs/prHPCGApr03.php**

**Caught in an Unhealthy Trap? Get Health Care Costs under Control Now**
*Grace-Marie Turner*
*Hispanic Trends*
*Winter 2003*

Spiraling premium costs and a sluggish economy are causing employees of small firms to lose their coverage faster than any other group, writes Grace-Marie Turner of the Galen Institute. In response, "Innovative firms are ... creating programs that give employees more incentive to be cost conscious."

Medical Savings Accounts and Health Reimbursement Arrangements can get employees more involved; Association Health Plans could help small businesses by pooling their exposure to risk and avoiding costly mandates and regulations; and refundable tax credits could help the uninsured, who are disproportionately Hispanic and working for small businesses.

*Source*: **www.hispaniconline.com/trends/2003/winter/managing/index.html**

*Material for this report is provided by The Galen Institute, PO Box 19080, Alexandria, VA 22320,* **http://www.galen.org**. *Grace-Marie Turner is president. The report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of* Health Care News.

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MYTURN

Conrad Meier

# Lies My Mother Never Told Me

The nature of a lie is such that if you repeat it often enough it takes on a life of its own, always at the expense of truth.

While some lies—"your hair looks great"—are harmless enough, and lies like "I never had sex with that woman" are laughable, others can be harmful to life, liberty, and the pursuit of health.

So it is with lies spoken in defense of single-payer health care. Consider:

**Lie #1 Single-payer systems are not socialized medicine.** Single-payer means government is the insurance company. It doesn't charge "premiums," but instead raises taxes. It controls not only the financing, but who gets what services, the quality of what they get, when they get it, and if they get it. A single-payer system is one big HMO, without the discipline and accountability achieved by competition and consumer choice. Sorry, but that's socialism.

**Lie #2 Single-payer systems are efficient.** A study by the Institute for Global Health at the University of California concluded the Kaiser-Permanente HMO in the United States and Britain's National Health Service (NHS) have similar resources, but the HMO offers better care more quickly. The difference is explained by better management, better use of integrated systems, greater investment in technology, and free-market competition.

**Lie #3 Single-payer systems are "free" for individuals.** Single-payer health care plans are not free: They are paid for by tax dollars. Billions of them. The Maryland proposal would have required a 33 percent increase in the state's personal income tax. Canadians pay extraordinarily high income taxes for their "free" care ... only to have to pay again when they come to the United States for care they can't get in Canada.

**Lie #4 Single-payer systems do not ration care.** In a single-payer health care system like Britain's, patients have every incentive to demand care, and lots of it. Since no system can satisfy unlimited demand, the central authorities must resort to the only strategy open to them: rationing. In single-payer systems, you get rationing by waiting list; rationing by price controls; and rationing by restricting access to specialists, technology, and new drugs.

**Lie #5 Single-payer systems offer high-quality care.** To get access to the least-invasive, most effective health care technology, citizens living under single-payer health care schemes come to the United States. The Canadian Fraser Institute reported in August 2002, "with regard to access to high-tech machinery, Canada performs dismally by comparison with other OECD countries. While ranking number one as a health care spender [among OECD countries with publicly funded universal health care systems], Canada ranks 18th in access to MRIs, 17th in access to CT scanners, [and] eighth in access to radiation machines ..."

**Lie #6 Single-payer systems offer timely care.** On any given day, one in 60 British citizens are waiting for medical treatment. Of those who are sick and actually need care, one in *six* must wait. One million people in Britain are on a waiting list for in-patient hospital admission at any given time. Just 155,000 of those are seen within four weeks. For 250,000 of them, it takes more than 26 weeks to be admitted for care.

**Lie #7 Single-payer systems improve access to prescription drugs.** In Britain, the government determines how much profit a pharmaceutical firm is allowed to make—a sure way to arrest research and development. In addition, they ration access to drugs with a lottery based on a consumer's zip code. The prize is your eligibility to receive free medication. The "lucky" zip code can change at any time, apparently on the basis of political expediency rather than medical necessity. Price controls and rigid drug formularies—hallmarks of a single-payer health care system—limit access to drugs and violate doctors' and patients' freedom of choice.

**Lie #8 Single-payer systems allow freedom of choice.** Many doctors already refuse to accept Medicare patients. A recent study by the American Medical Association found nearly half of all U.S. physicians would have limited their Medicare practices further if the federal government had carried out a plan to cut physician fees. How many more doctors would "opt out"—or quit the profession altogether—if the entire U.S. were one big Medicare program?

**Lie #9 Single-payer systems are popular with doctors.** Five hundred physicians leave Canada every year to practice in something other than a single-payer health care system. Zosia Kmietowicz wrote in the October 20, 2001 issue of the *British Medical Journal*, "one in four general practitioners (GPs) in Britain's National Health Service is seriously considering leaving general practice." The British Medical Association surveyed all 36,000 general practitioners in Britain, asking them if they would be prepared to resign from the NHS. There was a 66 percent response rate ... and 86 percent voted in favor of resignation.

**Lie #10 Single-payer systems are popular with patients.** In 2002, seventy-nine percent of Oregon voters rejected a plan to have government officials run a health care system for the state's 3.5 million residents. Measure 23, touted by supporters as "health care for all Oregon," attracted just 204,082 votes, 21 percent of the total, while 786,768 voters—79 percent—rejected it.

If we are to make informed choices about what trade-offs we are willing to make in our quest for universal health care, we need the truth. My Mother never told me these lies because she knew the truth. She was an immigrant from a country with a single-payer health care system.

*Conrad F. Meier is senior fellow in health policy at The Heartland Institute and managing editor of* Health Care News.


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